STATE OF MICHIGAN

DEPARTMENT OF LABOR & ECONOMIC GROWTH

OFFICE OF FINANCIAL AND INSURANCE SERVICES

Before the Commissioner of Financial and Insurance Services

In the matter of

XXXXX
Petitioner **File No. 86213-001**

v

Physicians Health Plan of Mid-Michigan
Respondent
_____/

Issued and entered
this 17th day of December 2007
by Ken Ross
Acting Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On November 6, 2007, XXXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Services (Commissioner) under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq*. On November 13, 2007, after a preliminary review of the material submitted, the Commissioner accepted the request for external review.

The issue in this external review can be decided by contractual analysis. The contract involved here is the PHP Plus Certificate of Coverage (the certificate) issued by Physicians Health Plan of Mid-Michigan (PHP). The Commissioner reviews contractual issues under MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

II
FACTUAL BACKGROUND

On February 27, 2007, the Petitioner had nuclear scans of the heart with radioactive isotopes and a stress test at the office of XXXXX, a network provider. PHP covered the

services, but applied a $10.00 copayment for the services.

The Petitioner asked PHP to waive the copayment. PHP denied the request and the Petitioner appealed. PHP maintained its denial and issued its final adverse determination letter dated October 17, 2007[1].

III
ISSUE

Did PHP properly charge a $10.00 copayment for the tests the Petitioner received?

IV
ANALYSIS

Petitioner's Argument

The Petitioner contends that the outpatient tests she received are diagnostic or x-ray tests and are covered at 100% under the terms of her benefit plan. She says the scans and stress test were not performed in her primary care physician's office, but in an imaging center located in the same building and therefore the $10.00 physician office copayment should not apply.

The Petitioner would like PHP to waive the $10.00 copayment it applied in this case because the services were not provided in her physician's office.

PHP's Argument

PHP says it correctly applied the copayment under the terms of the Petitioner's certificate. PHP bases its decision on the following provision in "Section 1: What's Covered – Benefits" on page 29 of the certificate, which describes coverage for physician's office services:

[1] The letter is dated October 17, 2007, but since the Petitioner did not complete PHP's internal grievance process until October 25, 2007, the date is probably an error.

Description of Covered Health Service	Is Notification Required?	Your Copayment Amount % Copayment are based on a percent of Eligible Expenses	Does Copayment Help Meet Out-of-Pocket Maximum?	Do You Need to meet Annual Deductible?
22. Physician's Office Services Covered Health Services received in a Physician's office including: **Covered Health Services for the diagnosis and treatment of a Sickness or Injury, including but not limited to:** • Radiology. • Pathology. • Diagnostic Services.	**Network** No **Non-Network** No	$10 per visit No Copayment applies for routine prenatal health services, or for adult and pediatric immunization, or for photochemotherapy for treatment for an approved diagnosis. 20%	No Yes	No Yes

PHP says that the Petitioner's radiology and diagnostic services are subject to the physician's office copayment under this provision and therefore the $10.00 copayment was appropriate.

Commissioner's Review

The focus of this analysis is whether PHP properly applied the $10.00 copayment to the services the Petitioner received on February 27, 2007. The Petitioner argues that she should not have to pay the copayment because she did not receive the services in a physician's office and that diagnostic and x-ray services in the past have been paid at 100%. The Commissioner finds that the $10.00 office visit copayment was correct under the facts of this case.

The Petitioner had four procedures on February 27, 2007. Three of those procedures (78465, 78478, and 78480) are identified on the statement the Petitioner received from XXXXX as "nuclear tests." The other procedure was 93015 (cardiovascular stress test with exercise)[2].

Regarding procedure 93015, the certificate makes clear, in the provision cited above, that radiology, pathology, and diagnostic services can be included under the "physician's office services" benefit and be subject to the $10.00 physician's office visit copayment.

[2] The statement also included a bill for A9500, supplies for radiologic procedures.

The resolution of this case turns, in part, on what is meant by the term "physician's office." The Petitioner's primary care physician practices with XXXXX, a physician practice group (i.e., a physician's office). XXXXX also has an imaging center in the same building, albeit on a different floor than the Petitioner's physician. The XXXXX offices are not a hospital. By any reasonable reckoning, procedure 93015 was a diagnostic service performed as a physician's office service and is subject to the copayment.

However, the certificate has other coverage for nuclear medicine. The certificate's "Description of Covered Health Services," on page 26 under "19. Outpatient Surgery, Diagnostic and Therapeutic Services, "says there is no copayment for:

> Covered Health Services for CT scans, PET scans, MRI, and nuclear medicine received on an outpatient basis in a Physician's office or at a Hospital or Network Alternate Facility. [Underlining added]
>
> Benefits under this section include the facility charge, the charge for required services, supplies and equipment, and all related professional fees.

The Commissioner concludes that if the Petitioner had only had the three nuclear tests on February 27, 2007, no copayment would have been required. However, the cardiovascular stress test was a physician's office service under the terms of the certificate and was subject to the $10.00 copayment.

The Commissioner finds the $10.00 copayment was appropriately applied to the Petitioner's services provided on February 27, 2007.

V
ORDER

The Commissioner upholds PHP's October 30, 2007, final adverse determination in Petitioner's case. PHP appropriately applied the $10.00 copayment for the diagnostic services on February 27, 2007, at XXXXX.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this

Order in the circuit court for the county where the covered person resides or in the Circuit Court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of the Office of Financial and Insurance Services, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.